

Child Sexual Abuse - Discovery, Professionalization and Institutionalization: 40 Years of Struggle and Progress in the USA

David L. Corwin, MD¹

Professor and Chief, Child Protection and Family Health Division Pediatrics Department,
University of Utah School of Medicine, U.S.A.

Brooks R. Keeshin, MD

Child Abuse Pediatrics Fellow, Cincinnati Children's Hospital Medical Center, U.S.A.

The first author wishes to acknowledge the contributions of Ray Helfer, Roland Summit, Gloria Powell, David Chadwick, David Finkelhor, Jill Korbin, John E.B. Myers, William Friedrich, Kathleen Faller, Lucy Berliner, John Conte, Kee MacFarlane, Barbara Boat, Mark Everson, Erna Olafson, Beverly James, Michael Grogan and many other professional friends and colleagues who worked together to help establish the professional field addressing child sexual abuse and other forms of child maltreatment. As teachers, mentors, co-workers and friends they have enlightened, guided and supported my professional development and work over these decades. With the thousands of other dedicated child abuse professionals, their efforts have advanced the protection and care for millions of children and adolescents who have experienced sexual abuse and probably helped prevent the sexual abuse of many more.

Introduction

Over the past four decades, the public and professional awareness of child sexual abuse in the United States of America has grown from almost none to daily public attention in newspapers and other news media with 68,500 reported sexual abuse victims in 2008 (U.S. Department of Health and Human Services, 2010). To confront this epidemic and other forms of child maltreatment, billions of dollars are spent annually on child protective services, law enforcement, legal proceedings, incarceration of perpetrators, out of home care for children when necessary for their protection, specialized child forensic interviewing centers and medical examinations, trauma focused treatment and prevention efforts. The incidence of child sexual abuse in the

¹ Medical Director, Primary Children's Center for Safe and Healthy Families
david.corwin@imail.org
801-231-9632

U.S. appears to have fallen approximately 60% compared to the early 1990's (Finkelhor, Turner, Ormrod, & Hamby, 2010). The societal and professional response to child sexual abuse is, hopefully, one of the reasons for this decline. This article describes some of the major developments, struggles and professional responses to child sexual abuse in America during the last four decades.

1970 to 1980-Rediscovering Child Sexual Abuse in the USA

During the 1960s and 1970s, the human rights, women's rights and sexual freedom movements contributed to increasing numbers of women entering the professions and an associated increased focus on child development. These social changes, combined with the medical discovery of physical child abuse in the United States, kindled the rediscovery of child sexual abuse as a major societal problem (Finkelhor, 1982). Child physical abuse and neglect began to emerge into public and professional attention during the 1960s following 1962 publication of the "Battered Child Syndrome" article by Henry Kempe and colleagues in the *Journal of the American Medical Association*. Medical interest in physical child abuse and neglect created fertile ground for the rediscovery of child sexual abuse nearly a decade later. This rediscovery of child sexual abuse was actually its third or fourth surfacing since 1850 but each prior discovery was re-suppressed (Olafson, Corwin, & Summit, 1993). Sigmund Freud first hypothesized in 1896 that early sexual seduction was the source of hysterical neurosis in adults he was treating. In response to disbelief, outrage and derision from his peers, Freud disavowed his "early sexual seduction" hypothesis and went on to develop competing theories about the role of fantasy in sexual development. These Freudian theories became the primary justification for dismissing children's disclosures of sexual victimization and instrumental in the continued suppression of child sexual abuse awareness over the next 70 to 80 years (Masson, 2003).

Human and women's rights advocates joined with social work, medical, nursing and mental health professionals to bring child sexual abuse into public and professional view (Finkelhor, 1982). Prior to the 70s and even through the middle 70s, the conventional view of incest was that it occurred with a frequency of around one case per million of population per year (Weinberg, 1955). In San Jose, California where humanistic psychologist Henry Giarretto and his wife, Anna, developed the Parents' United treatment approach for intra-familial child sexual abuse, the number of reported intra-familial cases of child sexual abuse approached 5,000 times that earlier estimate. The Giarrettos and their colleagues developed an approach to community treatment for intra-familial child sexual abuse that was contingent upon the perpetrators admission, deferred prosecution and satisfactory participation in outpatient treatment (Giarretto, 1982). Although it showed promise for a less adversarial approach to confronting

and treating intra-familial child sexual abuse, it gradually fell from favor and was replaced by a more aggressive criminal justice approach that raised the legal jeopardy facing accused perpetrators, mostly fathers and other male family members and friends. That trend contributed to the backlash against efforts to identify and protect sexually abused children that followed during the 1980s and 1990s as the fear of severe criminal punishments increased.

By the middle of the 1970s, child sexual abuse was added to the federally mandated and state implemented child abuse and neglect reporting laws that existed in all states by that time. In 1978 several professional books and lay books addressing child sexual abuse appeared. That same year, Roland Summit, a community psychiatrist in Los Angeles, California, published an article describing a continuum of sexual abuse of children that included 10 categories ranging from incidental sexual contact to perverse incest. The categories between those two ends of the spectrum, in increasing order of pathology, include ideological sexual contact, psychotic-intrusion, true endogamous incest, misogynous incest, imperious incest, pedophilic incest and child rape (Summit & Kryso, 1978). Reviewing this spectrum of child sexual abuse helps frame the diversity and the many different kinds and motivations associated with child sexual victimization. *Sexual Assault of Children and Adolescents*, one of the first professional books on child sexual abuse, was also published that year (Burgess, 1978). David Finkelhor, a sociologist at the University of New Hampshire, published his study on the prevalence of child sexual victimization among undergraduate students attending several New England colleges in the book *Sexually Victimized Children* (Finkelhor, 1979). By 1980, child sexual abuse began to explode into public and professional view.

1980 to 1990: Compelled to Action - Too Little Knowledge, Failed Cases and Backlash

The 1980s was a challenging decade for the professionals trying to address child sexual abuse allegations in the United States. The problem had exploded into public and professional view but the systems, professional guidelines, knowledge of physical findings indicative of sexual abuse, the best ways to interview children about such experiences and how to treat victimized children and those who abuse children did not exist or were in their infancy. No single professional discipline had enough interest or exclusive domain to address child sexual abuse by itself. Social workers and child welfare agencies were the first to act in concert with law enforcement and the courts. Pediatrics, psychiatry, and psychology followed, with each contributing a number of interested professionals but none taking child sexual abuse as a major focus for their profession.

In 1981, the first author (DLC) initiated and chaired the Los Angeles Task Force on Interviewing Sexually Abused Children that included members from each of the various professional disciplines involved in the investigation and interviewing of children in suspected cases of child sexual abuse. The LA Task Force was the first to recommend the use of video recording of these kinds of interviews with the goal of reducing the number of interviews with these children. The recommendation was presented nationally and internationally in 1982 (Corwin, 1988).

In the context of the professional uncertainty and legal battles that he had observed over the previous decade, beginning in the early 1970s, Roland Summit, a community psychiatrist at the Harbor/UCLA Medical Center, published “The Child Sexual Abuse Accommodation Syndrome” (Summit, 1983). Dr. Summit described the common elements of child sexual abuse cases from his consulting experience with over 2,000 cases around Los Angeles at various community agencies where he served as a consultant. He later clarified that the “Syndrome” was not intended as a diagnostic device but rather an educational tool for disabusing judges, jurors and others from commonly held misconceptions about child sexual abuse that were being used to attack the credibility of children in alleged child sexual abuse cases. In 1997, an international survey of experts on child abuse, designated Summit’s article as the second most influential publication in the child abuse field behind Kempe and colleagues’ “Battered Child Syndrome” (Oates & Donnelly, 1997).

Initial Efforts to Characterize the Phenotype of victims of Childhood Sexual Abuse

As awareness among the general public rose with regards to the prevalence of childhood sexual abuse, even though it became apparent that CSA is a heterogeneous grouping of varied degrees of sexualized experiences, patterns among victims were beginning to emerge. Two landmark theories describing specific phenotypic traits, behaviors and psychological reactions of victims were published in the mid 1980’s, both of which have been reinforced by decades of cross-sectional and longitudinal research: The Child Sexual Abuse Accommodation Syndrome and Traumagenic Dynamics.

The Child Sexual Abuse Accommodation Syndrome

The Child Sexual Abuse Accommodation Syndrome (CSAAS), proposed by Roland Summit, describes the phenomenon of CSA for many sexually abused children, especially prolonged, interfamilial forms of child sexual abuse (Summit, 1983). CSAAS is neither a diagnostic check-

list nor appropriate evidence to prove child sexual abuse. Its value in the legal, investigative, and clinical arenas is to counter attempts to use delayed disclosure and retraction to disprove sexual abuse. The syndrome further elucidates the countertransference and projection experienced by non-offending family members and professionals alike when confronted by reports of child sexual abuse. It explains developmentally understandable beliefs and coping strategies of children when they become victims of CSA. CSAAS includes five primary components: secrecy; helplessness; entrapment and accommodation; delayed, conflicted and unconvincing disclosure; and retraction.

Summit observed that sexual abuse more than other forms of maltreatment occurs in secret. There are typically no witnesses and the perpetrator uses threats or guilt to quiet the child. As a result, the child discerns the action is bad or wrong, but is also quite aware, either through direct or implied threat, that disclosing the abuse would cause serious negative consequences.

Most adults assume that a child who suffers sexual abuse would simply tell of the abuse at the first possible opportunity. However, research has demonstrated that this is not the case. Typically, children feel helpless because they lack the authority within the framework of the family to effectively oppose an adult caregiver or another authority. As a result of overwhelming feelings of helplessness, most children do not kick or scream out when sexually assaulted, but instead resort to such tactics as pretending to be asleep, hiding or simply dissociating from the experience.

Since the sexual abuse is rarely a one-time occurrence, and the child is already overcome by feelings of secrecy and helplessness, the child becomes entrapped in the cycle of abuse and must accommodate psychologically. This is partly why CSA often continues until the child matures or a third party discovers the abuse. Children accommodate psychologically through fragmentation, dissociation and in some extreme cases, the development of dissociative identity disorder.

As a result of the aforementioned coping strategies commonly used by victims of sexual abuse, delay in disclosure is more often the rule rather than the exception. When disclosure is delayed, often children will struggle in attempting to describe multiple episodes of victimization, leading to conflicting, inconsistent or unconvincing descriptions regarding specific episodes of abuse. A child who has delayed disclosure until after the abuse has ceased may also not look "victimized," either because the child has begun to engage in self-destructive behavior which makes them seem less reliable, or because the child has coped without any apparent effect on social or academic abilities. Either way, the child in this situation risks not looking the part of a "true victim" and a delayed or conflicting disclosure may reinforce a skepti-

cal response from many adults. This may especially be the case if acknowledging the true nature of the disclosure to a potential intervener significantly diminishes that adult's prior self-view as protector of the child.

Finally, children who do disclose will often take back their previous statement when they discover that many of their previous fears about disclosing were warranted. Non-offending family members often don't believe disclosures, the perpetrator abandons and blames the child, and the family can fragment when a report of sexual abuse is made. To many adults, a retraction may appear much more convincing than the original disclosure because at the moment of retraction, all of the doubts and questions of the adults are answered and the integrity of the family is restored.

Traumagenic Dynamics

Finkelhor and Browne theorized in 1985 that the core psychological injuries associated with childhood sexual abuse could be described in the four categories that comprise traumagenic dynamics: traumatic sexualization, betrayal, stigmatization and powerlessness (Finkelhor & Browne, 1985).

Traumatic sexualization refers to changes that occur in the child's feelings and attitudes towards sex and sexuality as a result of sexual abuse. Victims of CSA are often rewarded, taught misconceptions about sexual behavior and are conditioned to perceive sexual activity with negative emotions or memories. This results in increased knowledge of sexual issues, sexual confusion and inappropriate connection between sex and love. As a result, sexually abused children sometimes demonstrate increased sexual behaviors and developmentally inappropriate affect regarding potentially sexual topics.

There are two principle ways in which a victim of CSA may feel betrayed. First, in intra-familial CSA, a caregiver on whom the child depended causes direct harm to the child. Second, in either intra or extra-familial CSA, non-offending caregivers can either not believe or change their attitude towards the child once learning about the victimization. Again, the child feels betrayed by someone that they previously viewed as a protector with whom the child felt safe and secure. This perceived rejection can lead to depression, extreme dependency or mistrust, anger and an inability to judge trustworthiness in others.

Children who are victims, by definition, are unable to prevent the invasion of their bodies, cannot stop the abuse, and continue to fear future episodes of abuse, leading to a feeling of pow-

erlessness. This dynamic can be exacerbated if attempts to disclose are not believed. Anxiety, fear and lower self-esteem or an increased need for control and identification with the aggressor are often a result of this dynamic.

Stigma is the final psychological injury suffered by many CSA victims. Often children are blamed for the abuse and told to keep the abuse secret by either the abuser or non-offending caregivers. Furthermore, victims are given the impression, either directly or indirectly that they are “damaged goods.” The child learns to feel shame and guilt as a result of the abuse, and may view herself as different from others, leading to either isolation or maladaptive behaviors that originate from an increased need for acceptance. A significantly stigmatized child may even engage in self-mutilation or suicidal behavior.

Finkelhor and Browne assert that by understanding the core dynamics of child sexual abuse, one can anticipate and understand the origin of psychological reactions to child sexual abuse, with a child’s manifestation of symptoms categorized by one or more of the dynamics previously described. The child’s own psychological predispositions, environment and type of trauma impact how the child reacts to the different dynamics. This formulation helped focus research on the effects of abuse and it dictates treatment methods designed to diminish the psychological sequelae of childhood sexual abuse.

Behaviors and psychiatric disorders associated with sexual abuse

Parents are often concerned that a child who is asking questions of a sexual nature or engaging in sexual activities such as masturbation might be a victim of child sexual abuse. In order to help differentiate between normal and abnormal sexual behavior, William Friedrich, PhD developed the Child Sexual Behavior Inventory (CSBI), a scale that compares the sexual behavior of normal, psychiatric and sexually victimized children between 2 and 12 years of age. Non-abused young children exhibit sexual behavior that increases until about the age of 5 or 6, at which point observed sexual behavior significantly declines until right before adolescence (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998). Specifically, Friedrich observed that it is developmentally appropriate for 2-5 year olds to be sexually intrusive, standing too close to others, touching the breasts/genitalia of themselves or others or attempting to look at other’s genitalia. Furthermore, even though the overall rate dropped, Friedrich noted that greater than twenty percent of both boys and girls continued to touch themselves in private and look at others while undressing from the ages of 6-9 even though they are considered to be in their “latency” stage of sexual development. Finally, by the time children reached 10-12 years old, sexu-

ally intrusive behavior had greatly decreased and the only normative sexual behavior observed by parents was being very interested in the opposite sex.

Age inappropriate sexual behavior is strongly associated with CSA. However, physical abuse, neglect, exposure to domestic violence, excessive life stress and exposure to family sexuality can also result in inappropriate sexual behavior (Friedrich, et al.). Among pre-school age children, changes in sexual behavior are more common due to their lack of understanding of social norms. However, only one third of pre-school age CSA victims demonstrate abnormal sexual behavior (Brilleslijper-Kater, Friedrich, & Corwin, 2004).

There is some evidence to suggest that age-inappropriate sexual knowledge and emotional reactions may be more specific markers for CSA among young children (Brilleslijper-Kater, et al., 2004). When children learn about sex and sexuality in the context of a strong emotion-evoking experience such as CSA, sexuality becomes part of their knowledge base. This is in contrast to non-abused preschoolers who lack sexual knowledge and accompanying emotional reactions. Therefore, when asked about potentially sexual topics such as genitals or nudity, or shown pictures of people interacting in potentially sexual ways, non-abused children respond naively. The CSA victim however, is more likely to demonstrate knowledge of sexual behavior and function that is beyond their developmental stage. In the CSBI, inappropriate sexual knowledge is one of the most distinguishing factors between sexually abused and non-abused children (Friedrich, et al.).

Our understanding of the psychological sequelae of childhood sexual abuse has seen a refinement over the years. In his landmark review in 2003, Putnam noted PTSD and depression as two of the more serious and prominent consequences of sexual abuse in children (Putnam). Subsequent findings from two national adult cross-sectional epidemiology studies demonstrate the far-reaching psychiatric sequelae of exposure to childhood sexual abuse with increases in rates of depression, PTSD, drug dependence, anxiety and mood disorders (Green, et al.; Molnar, Buka, & Kessler).

In 1985, guidance and support by Drs. Roland Summit, David Chadwick, Denny Cantwell, the National Institute of Justice, several other agencies and foundations and other professional colleagues, this author and close colleagues brought together nearly 100 professionals from around the United States representing all of the major professional disciplines involved in addressing child sexual abuse cases to discuss the best approach for evaluating and identifying sexually abused children. That meeting was called the National Summit Conference on Diagnosing Child Sexual Abuse. Although the assembled professionals did not agree on a single new diagnostic formulation for sexually abused children, they strongly supported the need for a new

multidisciplinary professional society focused on developing professional guidelines for addressing child sexual abuse (Corwin, 1988). The following year, 1986, the California (CAPSAC) and the American Professional Societies on the Abuse of Children (APSAC) were formed. Although the impetus for their formation was the challenge to confront child sexual abuse, several influential professionals including David Chadwick, MD and Randall Alexander, MD objected to child sexual abuse as the single focus and the broader focus of child abuse and neglect was selected as the scope for the new American Professional Society on the Abuse of Children.

APSAC began the process of developing guidelines for professional work in the child abuse field. Around the same time, a prosecutor from Huntsville, Alabama, Bud Cramer began his efforts to promote the concept of Children's Advocacy Centers (CACs) where children involved in suspected child sexual abuse cases could be taken and interviewed in a more homelike environment than police or social service offices. That effort garnered support from prosecutors and allied professionals and communities across the United States. Today there are nearly 700 CACs.

By the late 1980s, the backlash against efforts to address child sexual abuse was gathering strength, bolstered by the failures to convict defendants in Jordan, Minnesota and in the McMartin Preschool case which ended as the most expensive criminal proceeding in the history of the United States. Victims of Child Abuse Laws (VOCAL) grew out of the Jordan, Minnesota case and spread throughout the country. Research on child witnesses was demonstrating the ability of young children to accurately and reliably report core experiences. Allegations of sexual abuse between separated parents had become a major focus and received extensive print and TV news coverage with the Morgan v. Foretich child custody dispute in Washington D.C. receiving the greatest national and international attention.

1990 to 2000: Backlash, Vulnerabilities of Child Witnesses, and Child Forensic Interviewer Training

The next wave in research on child witnesses explored their weaknesses when subjected to misleading and repeated suggestion. Cornell Psychologist, Stephen Ceci led the development and publication of such research (Ceci & Bruck, 1995). In response to concerns about how children were being interviewed in suspected child sexual abuse cases, week long training programs for child forensic interviewers began to appear in the late 1990s. Michael Lamb and Kathleen Sternberg, psychological researchers at the National Institute of Child and Human Development began collaborating with several other researchers and child abuse investigators in Israel and several communities throughout the United States on a series of studies designed to explore the best way for gathering accurate information from children in suspected child sexual abuse

investigations.

Programs and centers in children's hospitals that had begun to develop in the late 1970s and 1980s continued to expand and more physicians and other medical and allied health professionals began to focus on the assessment and evaluation of suspected child abuse including child sexual abuse. Research on treatment approaches for sexually abused children including Trauma Focused Cognitive Behavioral Treatment, TF-CBT, began showing promising results (Cohen, Mannarino, & Deblinger, 2006).

The Backlash continued in the United States and become more vicious in Great Britain. In the United States, a group of physicians working in the child abuse field came together and formed the Ray E. Helfer Society, an honorary professional society for physicians dedicated to working in the child abuse field. In the late 1990s, the United States' Federal Centers for Disease Prevention and Control (CDC) began to address child abuse as an important public health issue.

2000 to 2010: The National Child Traumatic Stress Network, the Health CARES (Child Abuse, Research, Education and Services) Network Proposal, the Academy on Violence and Abuse, the Child Abuse Pediatrics Subspecialty and the Adverse Childhood Experiences Study

On September 11, 2001, the same day as the attacks on the World Trade Center and the Pentagon, a group of professionals were meeting in Washington D.C. to draft the first request for proposals for what would become the largest federally funded effort to increase the availability of evidence-based treatment for traumatized children, including sexually abused children and their families. That program is the National Child Traumatic Stress Network (NCTSN). As a consequence of nationwide collaboration and increased research, the treatment of childhood sexual abuse has significantly evolved. Specifically, most current psychotherapies that target trauma related symptoms include components of exposure and cognitive processing. The only trauma therapy with multiple randomized controlled trials demonstrating its efficacy is Trauma Focused Cognitive Behavioral Therapy (TF-CBT) (Silverman, et al., 2008). TF-CBT is a manualized, 12-16 week, individual treatment for PTSD (Cohen & Mannarino, 2010). Therapy consists of psychoeducational, cognitive and stress reduction components, educating and involving the parents during the course of therapy and the development of a trauma narrative. For trauma, cognitive based therapies demonstrate a mean weighted effect size of 1.41 for the reduction of psychological distress (Hetzel-Riggin, Brausch, & Montgomery) and effect sizes of 0.71, 1.39 and 2.18 for the reduction of PTSD/trauma symptoms at 1-3 months, 4-6 months and >6 months follow up among sexually abused children (Harvey & Taylor). Factors that

increased effect size in reduction of PTSD symptoms of sexually abused individuals included a cognitive-behavioral foundation, manualized format, individual treatment and family involvement (Harvey & Taylor). Non-CBT based individual therapies, including Child-Parent Psychotherapy and Eye Movement Desensitization and Reprocessing therapy, target PTSD symptoms in children and have positive findings in the literature but less empirical support (Silverman, et al.). For more information about current efforts and research supported by the NCTSN, see www.nctsn.org.

A proposal to develop a national network of child abuse centers located in children's hospitals drew support from the American Academy of Child and Adolescent Psychiatry (AACAP), the American Academy of Pediatrics (AAP) and the National Association of Children's Hospitals and Related Organizations (NACHRI). The CDC injury prevention program has expressed interest in administering the Network but to date Congress has not appropriated any funding for the network.

In 2005, the Academy on Violence and Abuse (AVA), an international professional society for professionals interested in increasing the education of health professionals about violence and abuse across the lifespan, was founded. AVA grew out of the American Medical Association's National Advisory Council on Violence and Abuse. For more information about that society and its mission see www.avahealth.org.

The Adverse Childhood Experiences Study by Vincent Felitti and Robert Anda demonstrates high correlations between adverse childhood experiences, including child sexual abuse, and many of the most serious long-term health threats, diseases and other adverse health outcomes confronting the United States. A video-recorded lecture presenting some of the findings from that study can be viewed on the AVA website.

In 2005, the American Board of Pediatrics accepted the proposal to make "Child Abuse Pediatrics" the newest pediatric subspecialty in the United States. In the fall of 2009, the first examination for Board Certification in Child Abuse Pediatrics was held. In July of 2010, the first class of fellows began training under the newly accredited subspecialty of Child Abuse Pediatrics.

Conclusion

In the United States, Child sexual abuse began to re-emerge out of a half century of obscurity into professional and public attention during the 1970s. Over the last 40 years, the effort to

confront child sexual abuse along with the other forms of child maltreatment has involved thousands of professionals from many different disciplines. The multidisciplinary field addressing child sexual abuse and other forms of child maltreatment is now firmly established and institutionalized. There are now hundreds of books, thousands of professional publications, several multi-disciplinary professional societies and professional journals, the new pediatric subspecialty of “Child Abuse Pediatrics”, many legal developments, appellate and supreme court decisions, court improvements, a national network of Child Advocacy Centers and the National Child Traumatic Stress Network. With such an armada of enlightenment, child sexual abuse is unlikely ever to be suppressed again.

References

- Brilleslijper-Kater, S. N., Friedrich, W. N., & Corwin, D. L. (2004). Sexual knowledge and emotional reaction as indicators of sexual abuse in young children: theory and research challenges. *Child abuse & neglect*, 28(10), 1007-1017.
- Burgess, A. W. (1978). *Sexual assault of children and adolescents*. Lexington, Mass.: Lexington Books.
- Ceci, S. J., & Bruck, M. (1995). *Jeopardy in the courtroom : a scientific analysis of children's testimony* (1st ed.). Washington, DC: American Psychological Association.
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press.
- Cohen, J. A., & Mannarino, A. P. (2010). Psychotherapeutic options for traumatized children. *Curr Opin Pediatr*, 22(5), 605-609.
- Corwin, D. (1988). Early diagnosis of child sexual abuse - diminishing the lasting effects. In G. Wyatt & G. Powell (Eds.), *The Lasting Effects of Child Sexual Abuse*. Newbury Park: Sage Publications.
- Finkelhor, D. (1979). *Sexually victimized children*. New York: Free Press.
- Finkelhor, D. (1982). *Sexual abuse: a sociological perspective*. *Child Abuse and Neglect*, 6(1), 95-102.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: a conceptualization. *Am J Orthopsychiatry*, 55(4), 530-541.

Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. (2010). Trends in childhood violence and abuse exposure: evidence from 2 national surveys. *Archives of Pediatrics and Adolescent Medicine*, 164(3), 238-242.

Friedrich, W., Fisher, J., Broughton, D., Houston, M., & Shafran, C. (1998). Normative sexual behavior in children: a contemporary sample. *Pediatrics*, 101(4), E9.

Friedrich, W., Fisher, J., Dittner, C., Acton, R., Berliner, L., Butler, J., et al. (2001). Child Sexual Behavior Inventory: normative, psychiatric, and sexual abuse comparisons. *Child Maltreat*, 6(1), 37-49.

Giarretto, H. (1982). A comprehensive child sexual abuse treatment program. *Child abuse & neglect*, 6(3), 263-278.

Green, J. G., McLaughlin, K. A., Berglund, P. A., Gruber, M. J., Sampson, N. A., Zaslavsky, A. M., et al. (2010). Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. *Archives of General Psychiatry*, 67(2), 113-123.

Harvey, S. T., & Taylor, J. E. (2010). A meta-analysis of the effects of psychotherapy with sexually abused children and adolescents. *Clinical Psychology Review*, 30(5), 517-535.

Hetzel-Riggin, M. D., Brausch, A. M., & Montgomery, B. S. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: an exploratory study. *Child Abuse and Neglect*, 31(2), 125-141.

Masson, J. M. (2003). *The assault on truth : Freud's suppression of the seduction theory* (1st Ballantine Books ed.). New York: Ballantine Books.

Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health*, 91(5), 753-760.

Oates, R. K., & Donnelly, A. C. (1997). Influential papers in child abuse. *Child Abuse and Neglect*, 21(3), 319-326.

Olafson, E., Corwin, D. L., & Summit, R. C. (1993). Modern history of child sexual abuse awareness: cycles of discovery and suppression. *Child abuse & neglect*, 17(1), 7-24.

Putnam, F. W. (2003). Ten-year research update review: child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(3), 269-278.

Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., et al. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *J Clin Child Adolesc Psychol*, 37(1), 156-183.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child abuse & neglect*, 7(2), 177-193.

Summit, R., & Kryso, J. (1978). Sexual abuse of children: a clinical spectrum. *American Journal of Orthopsychiatry*, 48(2), 237-251.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children Youth and Families, & Children's Bureau. (2010). *Child Maltreatment 2009*.

Weinberg, S. K. (1955). *Incest behavior* ([1st ed.]. New York,: Citadel Press.